Table of Contents

State/Territory Name: CT

State Plan Amendment (SPA): CT-24-0009

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
230 South Dearborn
Chicago, Illinois 60604

Financial Management Group

November 19, 2024

Andrea Barton Reeves, J.D., Commissioner
Department of Social Services
55 Farmington Avenue, 5th Floor
Hartford, CT 06105-3730

RE: TN 24-0009

Dear Commissioner Reeves:

The Centers for Medicare & Medicaid Services (CMS) has reviewed the proposed Connecticut's state plan amendment (SPA) to Attachment 4.19-B of 24-0009, which was submitted to CMS on June 28, 2024. This plan amendment updates procedure codes and fee schedules while also adding reimbursement for donated human breast milk to eligible infants.

We reviewed your SPA submission for compliance with statutory requirements including in sections 1902(a)(2), 1902(a)(13), 1902(a)(30), and 1903 as it relates to the identification of an adequate source for the non-federal share of expenditures under the plan, as required by 1902(a)(2), of the Social Security Act and the applicable implementing Federal regulations.

Based upon the information provided by the state, we have approved the amendment with an effective date of April 1, 2024. We are enclosing the approved CMS-179 and a copy of the new state plan pages.

If you have any additional questions or need further assistance, please contact Jerica Bennett at 410-786-1167 or via email at jerica.bennett@cms.hhs.gov.

Sincerely,

[redacted]

Todd McMillion
Director
Division of Reimbursement Review

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 24 — 0009

2. STATE: CT

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT: (●) XIX ( ) XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
April 1, 2024

5. FEDERAL STATUTE/REGULATION CITATION
Social Security Act Sections 1905(a)(5),and (a)(7) and (a)(9) and 42 CFR 440.50 and 440.70 and 440.90

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2024 $ (673,618)
b. FFY 2025 $ (1,629,751)

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

Attachment 4.19-B, Pg 1(a)i(E) thru (I)
Attachment 4.19-B Pg 1(a)ix
Attachment 4.19-B Pg 1(b)ii
Attachment 4.19-B Pg 1(c)i
Supplemental 1 to Attachment 4.19-B Pg 4

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19-B, Pg 1(a)i(E) thru (I)
Attachment 4.19-B Pg 1(a)ix
Attachment 4.19-B Pg 1(b)ii
Attachment 4.19-B Pg 1(c)i
Supplemental 1 to Attachment 4.19-B Pg 4

9. SUBJECT OF AMENDMENT

1. Incorporate various April 2024 HCPCS updates for physician office & outpatient, MEDS, behavioral health clinic fee schedules; 2. Update eligible procedure codes for PCMH add-on payment; 3. Add select laboratory procedure codes to the family planning clinic fee schedule; 4. Add coverage of donated human breast milk to eligible infants; and 5. Update pharmacy reimbursement.

10. GOVERNOR'S REVIEW *(Check One)*

(●) GOVERNOR'S OFFICE REPORTED NO COMMENT
( ) COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
( ) NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
( ) OTHER, AS SPECIFIED:

[redacted]

12. TYPED NAME
Andrea Barton Reeves, J.D

13. TITLE
Commissioner

14. DATE SUBMITTED
June 28, 2024

15. RETURN TO
State of Connecticut
Department of Social Services
55 Farmington Avenue – 9th floor
Hartford, CT 06105
Attention: Ginny Mahoney

FOR CMS USE ONLY

16. DATE RECEIVED
06/28/2024

17. DATE APPROVED
November 19, 2024

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
04/01/2024

19. SIGNATURE OF APPROVING OFFICIAL
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
Todd McMillion

21. TITLE OF APPROVING OFFICIAL
Director, Division of Reimbursement Review

22. REMARKS

FORM CMS-179 (09/24)

Instructions on Back

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: CONNECTICUT

(5) Physician's services – Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of physician's services. The agency's fee schedule rates were set as of April 1, 2024, and are effective for services provided on or after that date. All rates are published on the Connecticut Medical Assistance Program website: https://www.ctdssmap.com. From this web page, go to "Provider," then to "Provider Fee Schedule Download," then select the applicable fee schedule.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: CONNECTICUT

Person-Centered Medical Home (PCMH) practices are individual sites of independent physician groups, solo physician practices, nurse practitioner groups, and individual nurse practitioners that have met National Committee for Quality Assurance (NCQA) Level 2 or Level 3 medical home recognition or NCQA medical home recognition under the 2017 or later NCQA standards (which do not recognize specific levels of recognition). PCMH practices must comply with all NCQA PCMH requirements and all additional written department requirements, including participation in various primary care initiatives operated by the State.

The department offers a PCMH Glide Path program, which pays enhanced rates to practices that are providing some of the additional Medicaid services required for NCQA PCMH recognition. In order to qualify for Glide Path, a practice must demonstrate that it has begun providing a more advanced standard of primary care and has committed to achieving NCQA PCMH recognition in a set period of time. Glide Path practices must also comply with all additional written department requirements, including participation in various primary care initiatives operated by the State.

Beginning January 1, 2012, PCMH and Glide Path practices may be eligible for a rate add-on to the procedure codes on the physician fee schedule identified below. PCMH practices may also be eligible for retrospective annualized supplemental payments for performance incentives and performance improvement. Independent physician-led Glide Path practices with five or fewer full-time equivalent practitioners across all practice locations may also be eligible for a supplemental payment at each Glide Path phase.

(a) Glide Path and PCMH Rate Add-On: The department will pay a rate add-on for the following procedures in addition to the amounts listed for each procedure code on the physician fee schedule: 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99406, 99407, 99408, 99409, 99411, 99412, 99417, 99374, 99377, 99379, 99380, 96110, 99050, 99051, 99053, 99442, 99443, G8431and G8510.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: CONNECTICUT

These codes were selected to pay providers for providing a more advanced level of primary care and to encourage more providers to provide primary care to beneficiaries, which will help expand access to primary care physicians' services. For a procedure provided to a beneficiary outside of the practitioner's office in a nursing facility, rest home, or the beneficiary's home, the applicable rate add-on will be paid if the beneficiary is attributed to the practitioner.

The base fees vary by practitioner type (physician, nurse practitioner, or physician assistant) according to the percentage of the physician fee schedule that is paid to each practitioner type. The rate add-on is paid at the same time as the underlying claim and is scaled based on the practice's stage of Glide Path or NCQA PCMH recognition:

i. For Glide Path practices, the total payment for each procedure code listed above, including the rate add-on, is 114% of the amount in the fee schedule.

ii. For NCQA Recognition Level 2, the total payment for each procedure code listed above, including the rate add-on, is 120% of the amount in the fee schedule.

iii. For NCQA Recognition Level 3, the total payment for each procedure code listed above, including the rate add-on, is 124% of the amount in the fee schedule.

Supplemental Payments for PCMH Practices: For PCMH practices only, the two types of supplemental payments detailed below will be paid to PCMH practices on a retrospective annualized basis based upon an attribution methodology, where recipients will be attributed to PCMH practices in accordance with the department's current written attribution methodology. The attribution methodology assigns recipients to primary care practitioners based on claims volume analyzed retrospectively every three calendar months. If a recipient receives care from multiple providers during a given period, the recipient is assigned to the practice that provided the plurality of care and if there is no single largest source of care, to the most recent source of care. Recipients may affirmatively select a PCMH practice as their primary care provider. After making a selection, regardless of the sources of care received prior to their selection during the period of claims measured in an attribution cycle, the recipient will be automatically attributed to their selected practice in the next attribution cycle. However, the recipient's selection will be overridden if, after making a selection, the recipient later receives more care from another practice in the same period of claims measured, although attribution is not changed if the recipient receives care from another practitioner within the same practice. Payments will be issued retrospectively in a lump sum on an annualized basis on or before December 31st for services provided in the previous calendar year (the "measurement year").

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: CONNECTICUT

Payment rates will not vary based on the practitioner type (physician, physician assistant, or nurse practitioner) to whom each recipient is attributed.

i. Supplemental Payment for Performance and Improvement: Independent physician groups, solo physicians, nurse practitioner groups, and individual nurse practitioners that meet all requirements for this supplemental payment will receive a payment totaling a maximum of the amount specified below for each member's enrollment month attributed to the practice. Payments will be issued retrospectively in a lump sum on an annualized basis on or before December 31st for services provided in the previous calendar year. The payment amount will be based on the practice's performance during the measurement year using the quality performance measures described in subsection (5)(c) below. PCMH practices are eligible for this payment only if they participate as a PCMH for the entire measurement year.

Performance Component: Each PCMH practice's performance on the quality performance measures are compared against all Medicaid-enrolled primary care practices that meet the minimum statistical thresholds for such measures and placed into percentiles, which are converted into points and averaged into a composite performance score. A practice earns 1 point for each measure where the rate is at or above the 75th percentile. A practice loses 1 point for each measure where the rate is at or below the 25th percentile. For measure rates that are between the 25th and 75th percentiles, the practice earns 0 points. Total earned performance points are then divided by the maximum possible earned points (i.e., the number of measures the practice qualified for) to yield the Performance Score.

Improvement Component: Each PCMH practice's earned points for improvement for each measure compared to the practice's rates from the previous year are calculated into a composite improvement score. A practice earns 1 point for each qualified measure where the rate for the current measurement year improved compared to the rate from the prior year. A practice loses 1 point for each qualified measure where the rate for the current measurement year worsened compared to the prior year rate. For rates that remain the same across both the measurement year and the year prior, the practice earns 0 points. Total earned improvement points are then divided by the maximum possible earned points (i.e., the number of measures the practice qualified for) to yield the Improvement Score.

Composite Score: Each qualified practice receives both the performance and improvement composite scores that range from -1 to 1. Those with high overall performance or high improvement receive higher scores (close to 1). Low performers and practices with no improvement receive lower scores (close to -1). The scored practices are plotted on the four-quadrant graph with performance on the Y axis and improvement on the X axis as shown in this graph:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: CONNECTICUT

Composite Score: Each qualified practice receives both the performance and improvement composite scores that range from -1 to 1. Those with high overall performance or high improvement receive higher scores (close to 1). Low performers and practices with no improvement receive lower scores (close to -1). The scored practices are plotted on the four-quadrant graph with performance on the Y axis and improvement on the X axis as shown in this graph:

The levels of per member per month payment are as follows:

Performance Quadrant	Supplemental Payment PMPM Amount
Quadrant 4	No payment
Quadrant 3	$0.30 PMPM
Quadrant 2	$0.30 PMPM
Quadrant 1	$0.50 PMPM

Challenge Pool Supplemental Payment:
In addition to the Performance and Improvement Supplemental Payment described above, practices that are in the 90th percentile of performance on the challenge pool measures referenced in subsection (c) below will be eligible to receive a challenge pool supplemental payment. This payment is $0.20 per member month, paid in the same manner and timeframe as the Performance and Improvement Supplemental Payment.

(c) Quality Performance Measures for PCMH Program. The department's quality performance measures for the PCMH program are updated as of January 1, 2021, and are effective for quality payments made on or after that date. The quality performance measures can be accessed and downloaded by going to the Connecticut Medical Assistance Program website: www.ctdssmap.com. Select "Information", then select "Publications", then scroll down to the section regarding the PCMH program. The quality measures are used to measure PCMH practices' performance and their eligibility for certain payments that are described in the relevant section of the plan as being made or determined using these quality measures. These quality measures are based on improving quality, access, and care outcomes.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State Connecticut

Home Health Services (Continued)

(d) Medical supplies, equipment and appliances suitable for use in the home – Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of medical supplies, equipment and appliances suitable for use in the home. The agency's fee schedule rates were set as of April 1, 2024, and are effective for services provided on or after that date. All rates are published on the Connecticut Medical Assistance Program website: https://www.ctdssmap.com. From this web page, go to "Provider," then to "Provider Fee Schedule Download," then select the applicable fee schedule. Over-the-counter products provided by pharmacies are reimbursed at Average Wholesale Price (AWP) with no dispensing fee, except for blood glucose testing strips which are reimbursed at WAC (Wholesale Acquisition Cost) with no dispensing fee and alcohol prep pads which are reimbursed at a maximum amount of $6.00 per 100 prep pads with no dispensing fee.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: CONNECTICUT

(c) Family Planning Clinics: Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of family planning clinic services. The agency's fee schedule rates were set as of April 1, 2024, and are effective for services provided on or after that date. All rates are published on the Connecticut Medical Assistance Program website: https://www.ctdssmap.com. From this web page, go to "Provider," then to "Provider Fee Schedule Download," then select the applicable fee schedule.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE: CONNECTICUT

(e) Behavioral Health Clinics: (e.1) **Private Behavioral Health Clinics.** Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of behavioral health clinic services. The agency's fee schedule rates for private behavioral health clinic services were set as of April 1, 2024, and are effective for services on or after that date. Fees for services provided to individuals 18 years of age and over will be 95% of the published fee.
All rates are published on the Connecticut Medical Assistance Program website: https://www.ctdssmap.com. From this web page, go to "Provider," then to "Provider Fee Schedule Download," then select the applicable fee schedule.

Effective January 1, 2012 the Department established a separate fee schedule for private behavioral health clinics that meet special access and quality standards, and such fees are higher than the fees available to clinics that do not meet such special standards. These clinics must accept all (100%) telephonic and walk-in referrals that present during business hours. All referrals must be screened by a trained intake worker or clinician and triaged to determine whether the referral is emergent, urgent or routine. A clinician must evaluate a client who presents at the clinic with an emergent condition within two (2) hours. Clients that undergo telephonic or walk-in screening and are determined to be in urgent need of services must be offered an appointment for an urgent face-to-face clinical evaluation with a clinician to take place within two (2) calendar days of the screening. Clients that undergo telephonic or walk-in screening and are determined to have routine needs must be offered an appointment for a routine face-to-face clinical evaluation with a clinician to take place within 14 calendar days of the screening. These clinics must have at least nine (9) extended hours per week beyond routine business hours of 8:00 AM to 5:00 PM. Providers that are designated Enhanced Care Clinics and have a valid Letter of Agreement with the Department that holds them accountable to the quality standards and access standards receive the enhanced rate for all routine outpatient services provided. The state monitors the access standards on a routine basis and provides access standard reports to the providers on a quarterly basis. The state has established a process for providers to submit corrective action plans (CAPs) if they do not meet the access standards for any reason except in increase in volume in excess of 20% compared to the same quarter of the previous year. All Enhanced Care Clinics must electronically register appointments made with the Administrative Services Organization (ASO).

(b) Prosthetic devices

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of prosthetic devices. The agency's fee schedule rates were set as of April 1, 2024, and are effective for services provided on or after that date. All rates are published on the Connecticut Medical Assistance Program website: https://www.ctdssmap.com. From this web page, go to "Provider," then to "Provider Fee Schedule Download," then select the applicable fee schedule.

(c) Eyeglasses

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of eyeglasses. The agency's fee schedule rates were set as of July 1, 2008, and are effective for services provided on or after that date. All rates are published on the Connecticut Medical Assistance Program website: https://www.ctdssmap.com. From this web page, go to "Provider," then to "Provider Fee Schedule Download," then select the applicable fee schedule.

(d) Hearing Aids

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of hearing aids. The agency's fee schedule rates were set as of March 1, 2019, and are effective for services provided on or after that date. All rates are published on the Connecticut Medical Assistance Program website: https://www.ctdssmap.com. From this web page, go to "Provider," then to "Provider Fee Schedule Download," then select the applicable fee schedule. The price allowed for hearing aids shall be the actual acquisition cost of the hearing aid(s) to the provider, not to exceed the applicable rates on the Hearing Aid/Prosthetic Eye fee schedule.